Impaired Professionals Procedure (IPP)
Task Force Committee Meeting
Friday, April 24, 2009

PRESENT: Edward Krall, MD; Kevin Martin; Julia Nelson, RN; Sandra Osborn, MD; Judy Warmuth, RN (arrived at 12:46); Ernest Witzke, RPh; Barbara McKinney (arrived 12:19); Shawnee Daniels-Sykes, PhD; Jack Zwieg, Sharon Henes, Jeanette Lytle,

EXCUSED: Burton Wagner, Sheryl Graber, Jeanne Severson

STAFF PRESENT: Tom Ryan, Bureau Director; Karen Rude-Evans, Bureau Assistant

GUESTS: Mickey Gabbert, Rogers Memorial Hospital

OPEN SESSION – CALL TO ORDER

Tom Ryan called the meeting to order at 12:05 p.m. A quorum of 9 members was present.

APPROVAL OF THE AGENDA

Amendments to Agenda

- After Item "C": Copy of CAC Seminar- Informational
- After Item "C": SHORT Program overview - Informational
- After Item "C": IPP Program Survey – Informational
- After Item "C": Brochure from the University of Utah - Informational

MOTION: Julia Nelson moved, seconded by Kevin Martin, to approve the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF MARCH 20, 2009 MEETING

MOTION: Kevin Martin moved, seconded by Ernest Witzke, to approve the minutes of March 20, 2009 as written. Motion carried unanimously.

REPORT ON THE NATIONAL ORGANIZATION OF ALTERNATIVE PROGRAMS 2009 ANNUAL CONFERENCE, APRIL 1-3, 2009 AUSTIN, TX

Sharon Henes reviewed the information from the National Organization of Alternative Programs Conference.

Trends in Prescription Drug Diversion and Use

Prescription drug abuse is rising in America, particularly in teenagers. The prescription drugs most often abused are Hydrocodone, OxyContin, Fentanyl and Methodone. Diversion occurs in many ways, including doctor shopping, internet, inappropriate prescribing, fraudulent prescriptions, illegal sales, employee theft, prescription rings, pharmacy theft and foreign diversion and smuggling into the United States.

All About Drug Testing

Drug testing is done because it works and addiction thrives in secrecy. Any tissues can be used, including urine, blood, hair, saliva, sweat and fingernails.

Drug testing problem areas discussed were:

- Collection sites cannot be controlled. May not always be doing observed screens.
- Third Party Administrators (TPA) do not always trigger no shows (should trigger when urine does not show up) which is more complicated to do than missed calls.
- Panel Selection
- Invalid, dilute, out of range and cancelled tests should be run anyway to determine what the problem is.
- Medical Review Officer (MRO) – Competence of the individual is quite varied. Anyone who takes the course can be an MRO.
- Relapse Reporting – making the complex simple. Relapse has shades of gray.

Relapse is a complicated issue, but any use is considered a relapse. Relapses include:

- Level I - Behavior Relapse (no chemical use but not going to AA/NA or therapy)
- Level II - Chemical relapse not in context of work
- Level III - Chemical relapse in context of practice.

20 Steps to Foolproof Drug Testing

1) Signing of a detailed monitoring agreement with the participant (including all substances to avoid, a clause that the participant agrees to be responsible for observed urine collection, etc.)
2) Development of competent collection sites. (Agreement with the collection sites regarding collection methods, including stipulation that all collections be directly observed.)
3) *Quality control and regular periodic follow-up of collection site to assure that proper collection methods are being maintained.
4) Provision of proper urine collection kits to collection sites.
5) Provision of financial arrangements.
6) *Periodic questioning of the participant to insure that specimen collection is being performed properly.
7) *Notification method to inform participant to obtain urine drug testing.
8) Monitoring no-call and no-show reports with appropriate action.

9) Monitoring compliance of submission of specimen within appropriate time frame following notification.
10) Competent testing of chain of custody urine samples at a qualified lab.
11) Appropriate testing of specimens (i.e. proper test, proper analysis, etc.) to include drugs of abuse used by health professionals (a more extensive and diverse panel than NIDA 5 screens).
12) Method for varying drug test panel as appropriate based on clinical situations, drug of choice, trends, etc.
13) System for routine confirmation (usually by GC/MS or LC/MS) of all screened positive results.
14) *Review of drug testing reports by medical review officer or other qualified personnel, with appropriate investigation, interview with participant to exclude appropriate use under physician care and reporting of positives.
15) *Entry or report notification and submission times into a database for analysis, storage, comparison and review.
16) Review of all non-negative reports (including: dilute, positive, adulterated, invalid or delayed reports) by staff.
17) Determination of level of relapse (i.e. Level I, II, III).
18) Reporting of relapse to appropriate authorities as needed or agreed.
19) Intervention with participant and referral for appropriate reevaluation.
20) Work with evaluation personnel to assure transfer of information and thorough reevaluation and receipt of reports.

*frequent problem areas

Task Force Recommendations – Current Status and Timeline for Completion

- Test more wisely and maintain closer contact with testers. (reference 20 Steps to Foolproof Drug Testing)
- Increase IPP staff based on the number of enrollees.
- Provide software for a computer (non-manual) monitor program.
- Include psychological/mental health impairments as part of IPP.
- Make IPP primary with caveats that you may be disciplined if not all information is disclosed up front. (Jack Zwieg will draft proposed language.) Boards need to have discretion to determine if action should be taken.
- Create a recommended list of all treaters with explicit expectations/job descriptions (DHS certifies all labs in Wisconsin).
- Referral Process
    - Exclusion is not conditioned on the source of the referral.
    - Can be referred through the screening panel
    - Change RL7 to allow credentialing applicants to enter IPP.
- Compliance/Completion
    - Relapse in context of work must be reported/referred for discipline, but may remain in IPP.

Structure of the Impaired Professionals Procedure Program – Discussion

First Lab has bought out NCPS, which leaves First Lab as our only third party administrator. Most states contract with only one lab. Some hospitals have asked if they could be used as collection sites, especially in rural areas where access is limited. Sharon Henes has had conversations with the senior manager at First Lab, and they are willing to work with the IPP to set up more collection sites in areas where they are needed. Random drug tests catch more offenders, but the recommendation is to test wiser and not more often.

Program outreach is needed to increase knowledge of IPP with all credential holders. Research shows that 10% of the population has some type of impairment and that 1% of the population should be in an IPP program.

Outsourcing Possibilities and Staffing of IPP

The Task Force recommends IPP staffing remain in-house. Contracting out can cause difficulties with continuity and coordination with the board and reporting.
Also recommended is to increase departmental staff based on the number of cases or at least to the former level of 2.5 positions.

Exclusion and Inclusion Criteria Discussion

Applicants to the IPP program are excluded if a complaint is received on the same incident prior to their initial contact with IPP staff. Currently there is a clause in the IPP contract that does not allow discipline on an IPP enrollee. Jack Zwieg was very concerned about this language, especially when there is harm to others from the action of the enrollee.

IPP should be primary with caveats that you may be disciplined if not all information is disclosed up front. Boards need to have the discretion to determine if action should be taken.

INFORMATIONAL ITEMS

Noted.

PUBLIC COMMENTS

None.

OTHER TASK FORCE BUSINESS

None.

ADJOURNMENT

The meeting adjourned at 4:20 by consensus.

NEXT MEETING: MAY 27, 2009 AT 12:00 P.M.